

OVERVIEW OF FEDERAL HEALTH CARE REFORM

Items of Interest to Employers and Sole Proprietors

On March 23, 2010, President Barack Obama signed H.R. 3590, the Patient Protection and Affordable Care Act. This measure along with clarifying amendments contained in H.R. 4827 signed on March 30, 2010, usher in significant changes to the health care coverage system in the United States. Throughout discussions of reform there was near universal agreement that changes to our current system were necessary to improve access and affordability of coverage. Key philosophical differences divided Congressional leaders from beginning to end. The final compromise legislation that moved forward represents agreements between majority parties in the House and Senate and President Obama.

With the passage of these bills, the Congressional Budget Office (CBO) and the federal Joint Committee on Taxation (JCT), estimate that 32 million more Americans will be insured by 2019, most of these through new government programs created in the legislation. The CBO and JCT also estimate that the reforms will cost approximately \$940 billion over the next 10 years, financed primarily by new taxes and fees on employers, individuals and health care stakeholders, as well as with revisions to our current Medicare and Medicaid programs.

The primary goal for Congressional leaders was to expand coverage and the structure and subsidies designed may indeed accomplish that goal. New government programs providing coverage and premium subsidies to low-income individuals and families, small employer tax credits to make coverage more affordable for business owners, and expansions of entitlement programs will provide much needed assistance to those who currently cannot afford to purchase coverage. However, key to sustaining coverage is affordability and while there are a few elements within the bills aimed at lowering costs, there are numerous elements that will unfortunately raise the cost of health care coverage for all. New and expanded benefits, reductions in allowable deductibles and cost sharing, new taxes on insurers and health care suppliers that will be passed on to purchasers, and restrictions on the amount of money that can be contributed to FSAs, HSAs and Archer MSAs will all increase the cost of health care coverage from this point forward.

The legislation charts a course covering the next ten years in order to allow appropriate time to get new programs operational; allow employers to plan for new coverage requirements, corresponding penalties and the loss of existing subsidies; allow insurers to revise health policies; and begin collection of new taxes to support the new programs. During this time, implementation will be guided by new rules and regulations at both the state and the federal levels, thus making it impossible to know the final impact these changes will have on the marketplace until full implementation is achieved.

However, in anticipation, employers and sole proprietors should be aware of at least the following as implementation begins to unfold:

- New tax credits for small employers purchasing health care coverage beginning in 2010
- New taxes on unearned income (including income from the sale of a home) beginning in 2013
- Coverage and reporting requirements for employers with more than 50 employees beginning in 2014
- New coverage expansions and benefit requirements beginning in 2010

The following provides a breakdown of the major provisions pertinent to the employer community and individuals in their roles as sole proprietors, and includes the anticipated timeline for implementation of the varied items. Additional components addressing changes to the Medicaid and Medicare programs, and health care provider and stakeholder communities that do not have a direct impact on employers have not been included in this analysis.

<p>2010</p>	<p>Insurance/Coverage Reforms</p>	<p>IMPACTING GROUP AND/OR INDIVIDUAL HEALTH PLANS</p> <ul style="list-style-type: none"> • <u>Lifetime Limits, Annual Limits, Pre-Existing Condition Exclusions, and Recissions:</u> Prohibits insurers from imposing lifetime limits on benefit payments and restricts annual limits on covered services. Prohibits insurers from rescinding coverage except for fraud; and denying coverage to children under 19 with pre-existing conditions. Provisions apply to both new and existing health plans (H.R. 3590, Secs. 2712 and 10101; and H.R. 4872, Sec. 2301) • <u>Preventive Services:</u> Eliminates co-payments and deductibles for preventive care in all new group and individual health plans. (H.R. 3590, Sec. 2713) • <u>Dependent Coverage:</u> All individual and group policies providing coverage to dependents (including those in existence prior to the effective date) are required to extend coverage to employees' unmarried dependents up to age 26 that lack access to other employer-sponsored coverage. (H.R. 3590, Sec. 2714; and H.R. 4872, Sec. 2301) • <u>Discrimination Based on Salary:</u> Employers are prohibited from limiting eligibility for health care coverage based on wages or salaries of full-time employees (does not apply to self-insured plans). (H.R. 3590, Sec. 2716) • <u>Other Changes/Plan Requirements:</u> For new plans, eliminates preauthorization requirements for emergency services and prohibits different cost-sharing requirements for emergency services provided by a non-participating provider. Requires direct access to OB-GYN services. (H.R. 3590, Sec. 2719) • Existing plans, referred to as grandfathered plans (those in place prior to March 23, 2010) may lose status upon renewal (the new law is not clear as to when grandfather status is no longer granted). For coverage under a Collective Bargaining Agreement, all new coverage and cost-sharing rules will apply when the coverage portion of the existing agreement is terminated, as long as the agreement was ratified prior to March 23 (the day the law took effect). Coverage amendments required to comply with the new law will not terminate the agreement. (H.R. 3590, Sec. 2716)
--------------------	--	--

		<p>IMPACTING HEALTH INSURERS</p> <ul style="list-style-type: none"> • <u>Medical Loss Ratio Reporting:</u> Requires insurers in the individual and small group market to spend 80 percent of premiums on medical services, and insurers in the large group market to spend 85 percent of premiums. Insurers that do not meet these thresholds must provide rebates to policyholders. (H.R. 3590, Sec. 2718) • <u>Premium Increase/Rate Review:</u> The Department of Health and Human Services is to establish a process to review unreasonable increases in health plan premiums and require plans to justify those increases. (H.R. 3590, Sec. 2794) • <u>Appeals Process:</u> Requires health plans to offer a mandatory internal and external claims appeal process. Washington already requires insurers to have such a process. (HR 3590, sec. 2719)
	<p>New Taxes, Credits and Fees</p>	<ul style="list-style-type: none"> • <u>Indoor Tanning Services Tax:</u> Beginning July 2010, a new tax of 10% will be imposed on indoor tanning services. (HR 3590, sec. 10907/sec. 5000B) • <u>Black Liquor Biofuel Credit Repeal:</u> Unprocessed fuels, including the “black liquor” byproduct of paper processing, will no longer qualify for the \$1.01 per gallon cellulosic biofuels credit. (H.R. 4872, Sec. 1402) • <u>Small Employer Tax Credit - Phase I:</u> In 2010-2013, a tax credit of up to 35% of coverage costs is available for small employers. (HR 3590, Sec. 1421(45R) and Sec. 10105) <ul style="list-style-type: none"> ○ Full credit available to firms with up to 10 employees with average wages below \$25,000; credit phases out for firms with 10-25 employees and average wages \$25,000-\$50,000 ○ Employers must contribute at least 50% of the total premium cost or 50% of a benchmark premium once established in order to qualify for the tax credit. • <u>Tax-Exempt Small Employers Tax Credit – Phase I:</u> In 2010-2012, a tax credit of 25% of coverage costs available to tax-exempt small employers; tax credit increases to 35% in 2013 and beyond (HR 3590, sec. 1421 (45R))
	<p>Coverage Expansions</p>	<ul style="list-style-type: none"> • <u>Temporary High-Risk Pool for Individuals:</u> Creates a temporary national high-risk pool to provide coverage to individuals with pre-existing medical conditions (U.S. Citizens and legal immigrants) uninsured for at least 6 months. Premiums will be subsidized for individuals in the high-risk pool. Existing state high risk pools may qualify to provide such coverage. Washington has a high risk pool but enrollees will not qualify for subsidies. The national high risk pool and subsidies will be available through January 1, 2014. (H.R. 3590, Sec. 1101)

	<p>Other Changes</p>	<ul style="list-style-type: none"> • <u>Temporary Reinsurance Program for Employers Providing Retiree Coverage:</u> This reinsurance program is intended to help support employer sponsored health coverage provided to retirees over age 55 who are not eligible for Medicare. The program will reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000. The program will be available until Jan. 1, 2014. (H.R. 3590, Sec. 1102) • <u>Accommodations for Breast-Feeding Mothers:</u> Employers must provide appropriate break time and space other than a bathroom for breast-feeding mothers to express breast milk. Exemptions exist for employers with fewer than 50 employees. (HR 3590, sec. 4207) • <u>Internet Portal for Consumers:</u> Requires the Department of Health and Human Services to establish a new Internet website to help individuals/consumers identify health coverage options. (H.R. 3590, Sec. 1103) • <u>Provider Discrimination:</u> Prohibits insurers from discriminating against a health care provider acting within the scope of their license and state laws. (HR 3590, sec. 2706) <p>Prohibits federal and state gov'ts from discriminating against providers that refuse to perform services related to "assisted suicide, euthanasia, or mercy killing" (HR 3590, sec. 1553)</p>
<p>2011</p>	<p>Insurance/Coverage Reforms</p>	<ul style="list-style-type: none"> • <u>Voluntary Long Term Insurance:</u> Establishes a national, voluntary insurance program for the purchase of community living services and supports (otherwise known as the CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of \$50 per day to purchase non-medical services and support necessary to maintain community residence. The program is financed through voluntary payroll deductions; however, all working adults are responsible for opting out, as they will be automatically enrolled in the program. Employers will need to institute automatic payroll deductions for participating employees. (H.R. 3590, Secs. 3203-3205)
	<p>New Taxes, Credits and Fees</p>	<ul style="list-style-type: none"> • <u>Tax Changes to HRAs, FSAs, and HSAs:</u> HSA, FSA, HRA and Archer MSA expenditures for medicines and drugs are limited to prescriptions and insulin only (includes prescribed over-the-counter drugs). The changes also increase the tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and 15% for Archer MSAs) of the disbursed amount. (H.R. 3590, Secs. 9003 and 9004) • <u>Pharmaceutical Manufacturing Fees:</u> First annual fee takes effect in the amount of \$2.5 billion and increases to \$4.2 billion in 2012 through 2018, and \$2.8 billion thereafter. (H.R. 3590, Sec. 9008)
	<p>Other Changes</p>	<ul style="list-style-type: none"> • <u>Employer W-2 Reporting:</u> Employers are required to begin reporting value of their health benefits on W-2s. (H.R. 3590, Sec. 9002)

		<ul style="list-style-type: none"> • Standards for Coverage Information: The Department of Health and Human Services, in consultation with the National Association of Insurance Commissions, is responsible for developing standards for insurers to use in providing information to enrollees on benefits and coverage (insurers must comply with these standards by 2012). (H.R. 3590, Sec. 2715) • Nutritional Information Disclosure: Chain restaurants (those with 20 or more locations) and food sold from vending machines are required to disclose the nutritional content of each item (federal regulations will be issued in 2011 for compliance moving forward). (H.R. 3590, Sec. 4205)
2012	Other Changes	<ul style="list-style-type: none"> • Expanded 1099 Reporting: All businesses are required to submit 1099s for all business-to-business or business-to-individual transactions (excluding wages and salaries) exceeding \$600
2013	Insurance/Coverage Reforms	<ul style="list-style-type: none"> • Consumer Operated and Oriented Plan (CO-OP) Program: The reform law appropriates \$6 billion in grants for the development of nonprofit, member-run health insurance cooperatives that will offer qualified health benefit plans. Grants will be awarded in 2013. (HR 3590, sec. 1322)
	New Taxes, Credits and Fees	<ul style="list-style-type: none"> • Tax Changes to FSAs: Limits the amount of contributions to flexible spending accounts for medical expenses to \$2,500 per year increased annually by the cost of living adjustment. (H.R. 3590, Sec. 9005) • Itemized Deduction for Unreimbursed Medical Expenses: Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% to 10% of adjusted gross income for regular tax purposes and waives the increase for individuals age 65 and older for tax years 2013 through 2016. (H.R. 3590, Sec. 9013) • Medicare Payroll Tax: Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly. (H.R. 3590, Sec. 10906) • Medicare Tax on Unearned Income: Imposes a 3.8% tax on unearned income (capital gains, interest, dividends, and other net income, including some profits from investments and in partnerships and S-Corporations) for higher-income taxpayers (over \$200,000 for individual taxpayers and \$250,000 for a married couple filing jointly). The thresholds are not indexed. (H.R. 4872, Sec. 1402) • Medicare Part D: Eliminates the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments. (H.R. 4872, Sec. 1407) • Tax on Medical Devices: Imposes an excise tax of 2.9% on the sale of any taxable medical device after December 31, 2012. (H.R. 4872, Sec. 1405)

	<p>Other Changes</p>	<ul style="list-style-type: none"> • State Compacts and National Plans: States may develop interstate compacts that allow insurers in participating states to sell policies in any state participating in the compact. Compacts may take effect after January 1, 2016. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. (H.R. 3590, Sec. 1333) • Health Insurance Administrative Simplification: Health plans must follow single set of operating rules governing eligibility verification and claims status (federal rules to be adopted by July 1, 2011). (H.R. 3590, Sec. 1104)
<p>2014</p>	<p>Insurance/Coverage Reforms</p>	<ul style="list-style-type: none"> • Employer Coverage Requirements: Employers with over 50 full-time employees (30 hrs and above) that do not provide coverage will pay \$166.67 per month (or \$2,000 per year) per full-time employee if they have an employee that accesses a federal premium credit. (H.R. 3590, Sec. 1513, and H.R. 4872, Sec. 1003) <ul style="list-style-type: none"> ○ Employers may subtract the first 30 employees from the calculation ○ A full-time employee is defined as an employee that works more than 30 hrs per week ○ Employers must calculate FTEs for all part-time employees by adding the number of hrs such employees work and dividing by 120 (seasonal employees are exempt from the calculation) <p>Beginning in 2014, employers with over 50 full-time employees (30+ hrs) that do provide coverage, may also be responsible for an additional assessment if one or more of their employees qualifies for a federal premium credit. Employees will be eligible for the premium credit if employee cost-sharing in the employer plan is between 8-9.8% of the employee's income. The assessment is the lesser of \$750 times the number of employees receiving a premium credit or \$3,000 times the number of employees. (H.R. 3590, Sec. 1513, H.R. 4872, Sec. 1003)</p> <ul style="list-style-type: none"> ○ Employers that provide coverage are required to offer a voucher to employees with incomes below 400% FPL when an employee's share of the premium cost is between 8-9.8% of income to enable the employee to enroll in an exchange health plan. The voucher must be equal to the cost the employer would contribute if the employee enrolled in the employer's plan and employers providing the voucher will not be assessed the above penalty. Employees are allowed to keep excess voucher amounts if the voucher exceeds the cost of plans under the Exchange. Employers providing free choice vouchers are not subject to penalties for employees that receive premium credits in the Exchange. (H.R. 3590, Sec. 10108, and Sec. 139D) <p>Employers with fewer than 50 employees are exempted from the coverage penalties identified above.</p> • Automatic Enrollment in Coverage: Employers with more than 200 employees are required to automatically enroll employees in health insurance plans offered by the employer; however, employees may opt out of coverage. (H.R. 3590, Sec. 1511)

- **Mandatory Reporting:** All employers with 100+ employees must report coverage provided to employees and the names of employees enrolled in their plan to the federal government (HR 3590, sec. 1514)
- **Individual Coverage Mandate:** All U.S. Citizens and legal residents are required to obtain qualifying coverage. Those without coverage will be subjected to a new penalty as follows:
 - \$95* or 1% of income in 2014
 - \$325* or 2% of income in 2015
 - \$695* or \$2.5% of income in 2016
 - Penalties indexed by base to CPI beyond 2016

(* penalties are paid per adult in household with 50% of penalty applied per child in the household, up to a cap of \$2,250 per family) (HR 3590, sec. 1501/sec. 10106; and H.R. 4872, Sec. 1002)

Exemptions granted for financial hardship, religious objections, American Indians, those without coverage for less than 3 months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was \$9,350 for singles and \$18,700 for couples). (H.R. 3590, Secs. 1501 and 10106)
- **Qualified Health Plans:** Insurers will be prohibited from offering new health benefit plans that are not otherwise identified as "qualified health plans." All qualified health benefits plans, including those offered through the Exchanges and those offered outside of the Exchanges, must meet predetermined standards that include specified essential health benefits offered within one of four-tiered benefit designs. Qualified plans must also limit annual cost-sharing to the current HSA limits (\$5,950/individual and \$11,900/family), and may not be more extensive than the typical employer plan. The Secretary of HHS is required to define and annually update the benefit package through a transparent and public process. Individuals and employers that fail to purchase a qualified health plan may be subject to the penalties described above. (H.R. 3590, Secs. 1301, 1302 and 2707)
- **Market Merge Option:** States allowed to merge the individual and small group markets. (H.R. 3590, Sec. 1312)
- **Guarantee Issue and Rating Restrictions:** Health plans in the individual and small markets, as well as those plans within the Exchange are required to guarantee issue and renewability and allow rating variation based only on age (limited to 3:1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5:1 ratio). Risk adjustment is also required for these health plans- both inside and outside of the Exchange. (H.R. 3590, Secs. 2701-2703)

		<ul style="list-style-type: none"> • <u>Pre-Existing Condition Exclusions:</u> All plans (new and existing) are prohibited from imposing pre-existing condition exclusions on adults and from discriminating against an individual based on health condition (H.R. 3590, secs. 2704 and 2705) • <u>Preventive Services:</u> Eliminates co-payments and deductibles for preventive care in all group and individual health plans that were issued prior to March 23, 2010. (H.R. 3590, Sec. 2713 and Sec. 10406) • <u>Deductible Limits:</u> Deductibles for health plans in the small group market are limited to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits. (H.R. 3590, Sec. 1302) • <u>Waiting Periods:</u> Limits employer required waiting periods for enrollment in coverage to a maximum of 90 days (this also applies to existing or “grandfathered” plans). (H.R. 3590, Sec. 2708) • <u>Lifetime and Annual Limits:</u> Prohibits all plans (new and existing) from imposing lifetime limits and any annual dollar limits for essential benefits. (H.R. 3590, Secs. 2712 and 10101; and H.R. 4872, Sec. 2301) • <u>Clinical Trials:</u> Requires coverage for approved clinical trials. (H.R. 3590, Sec. 2709 and Sec. 10103)
	<p>Coverage Expansion</p>	<ul style="list-style-type: none"> • <u>New State Health Insurance Exchange:</u> Each state is required to establish a health insurance exchange to be administered by a governmental agency or non-profit organization through which individuals and employers with up to 100 employees can purchase qualified coverage. Federal funding for state Exchanges is available in 2011 through January 1, 2015, but Exchanges are not required until 2014. Individuals and families participating in the exchanges are eligible for premium and cost-sharing subsidies. (H.R. 3590, Secs. 1311 and 1321). Washington already has a small employer Exchange known as the Health Insurance Partnership administered by the Washington State Health Care Authority that will qualify for the federal funding. <ul style="list-style-type: none"> ○ <u>Benefit Tiers/Standards:</u> Each Exchange must offer at least one health benefit plan at each tier of coverage, plus a separate catastrophic plan that is available to those up to age 30 or those who are exempt from the mandate to purchase coverage (catastrophic plans are only available in the individual market). The benefit tiers also provide for reduced out-of-pocket limits for those with incomes between 100% and 400% FPL. (H.R. 3590, Sec. 1302)

		<ul style="list-style-type: none"> ○ Multi-State Plans in the Exchange: The federal Office of Personal Management is required to contract with insurers to offer at least 2 multi-state plans in each Exchange. Multi-state plans must be licensed in each state and must meet the requirements of a qualified health plan. (H.R. 3590, Sec. 1334) ● Basic Health Plans: States are given the option of creating a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more insurers to provide at least the lowest tier essential health benefit plan. States must ensure that eligible individuals do not pay more in premiums in the Basic Health Plan than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the highest tiered benefit plan (the Platinum Plan) for enrollees with income less than 150% FPL or the next highest tiered benefit plan (the Gold Plan) for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating these plans will not be eligible for subsidies in the Exchanges. (H.R. 3590, Sec. 1331). Washington state's Basic Health Plan already qualifies for initial funding for this program but current benefits will need to be adjusted in the future to conform with the essential health benefit requirements. ● Medicaid Expansion: States are required to cover all individuals under the age of 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL. All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. States will receive 100% federal funding for expansion of coverage through 2016 (eventually stepping down to 90% in 2020 and beyond). States that already have expanded eligibility to adults with income up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage for non-pregnant childless adults so by 2020 they receive the same federal financing (90%) as other states. (HR 3590, sec. 2001)
	<p>New Taxes, Credits and Fees</p>	<ul style="list-style-type: none"> ● Individual Mandate Penalty: All U.S. Citizens and legal residents are required to obtain qualifying coverage. Those without coverage will be subjected to a new penalty as follows: <ul style="list-style-type: none"> ▪ \$95* or 1% of income in 2014 ▪ \$325* or 2% of income in 2015 ▪ \$695* or \$2.5% of income in 2016 ▪ Penalties indexed by base to CPI beyond 2016 (* penalties are paid per adult in household with 50% of penalty applied per child in the household, up to a cap of \$2,250 per family) (HR 3590, sec. 1501/sec. 10106; and H.R. 4872, Sec. 1002)

- **Employer Coverage Penalty:** Employers (with more than 50 employees) that do not offer coverage and have at least one full-time employee taking advantage of federal premium assistance must pay a fee of \$166.67 per month or \$2,000 year, per full-time or full-time equivalent employee (first 30 employees are exempt).

For example, an employer with 51 employees would pay a total annual penalty of 51-30 (\$2,000) or \$42,000 a year.

Employers (with more than 50 employees) that do offer coverage, but have at least one full-time employee taking advantage of federal premium assistance must pay the lesser of \$3,000 per employee receiving a premium credit or \$750 for each full-time employee.

For example, an employer with 51 full-time employees, only 2 of which are taking advantage of the federal premium assistance program, would pay an annual fee of \$6,000 (because the penalty per premium assistance employee is lower than the penalty assessed per full-time employee), but an employer with 51 full-time employees, 25 of which are taking advantage of the federal premium assistance program would pay an annual fee of \$19,500 (because the penalty per full-time employee is lower than the penalty assessed per premium assistance employee).

The fee on employers is not tax deductible. (*The CBO estimates the cost of this penalty to be nearly \$30 billion through 2019.*) (H.R. 3590, Sec. 1513, H.R. 4872, Sec. 1003)

- **Small Business Tax Credit- Phase II:** For tax years 2014 and later, a tax credit of up to 50% of a small employer's contribution toward the employee's health insurance premium is available for eligible small businesses purchasing coverage through a state or national Exchange. Those purchasing coverage in the private market may qualify for the credit based on a benchmark premium amount established through the exchange. Eligible employers are limited to businesses with fewer than 25 employees that pay wages below a threshold to be determined, and contribute at least 50% of the total premium cost. The credit will be available for 2 years.

The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000, with the credit phasing out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium. (HR 3590, Sec. 1421(45R) and Sec. 10105)

		<ul style="list-style-type: none"> • Premium Credits: Provides refundable and advance payment premium credits to eligible individuals and families with incomes between 133-400% FPL to purchase coverage through an Exchange. The premium credits are set on a sliding scale and tied to a percentage of income per specified income levels. (H.R. 3590, Sec. 1412) • Cost-Sharing Subsidies: Cost-sharing credits are available to eligible individuals and families between 100%-400% FPL to reduce cost-sharing amounts and annual cost-sharing limits. Credits will increase the actuarial value of the basic benefit plan to specified percentages of the full value of the plan (based on income). (HR 3590, Sec. 1411) • Health Insurer Fees: Imposes a new annual fee schedule for health insurers, starting with an \$8 billion fee in 2014. For non-profit insurers, only 50% of new premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations not established by an employer. (HR 3590, Sec. 9010 and H.R. 4872, Sec. 1406)
	<p>Other Changes</p>	<ul style="list-style-type: none"> • Temporary Reinsurance Program: Creates a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. (The reinsurance program sunsets on December 31, 2016). (HR 3590, Sec. 1341) • Health Insurance Administrative Simplification: Health plans must adhere to a single set of operating rules governing electronic funds transfers, healthcare payments and remittance (federal rules to be issued by July 1, 2012). Rules will also be issued by July 1, 2014 governing standards for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization for health plan compliance by January 1, 2016. (HR 3590, Sec. 1104 and Sec. 10109)
<p>2015</p>	<p>New Taxes, Credits and Fees</p>	<ul style="list-style-type: none"> • Individual Mandate Penalty Increase: Penalty for lack of coverage increases to the greater of \$325 or 2% of taxable income. (HR 3590, sec. 1501/sec. 10106; and H.R. 4872, Sec. 1002) • Health Insurance Provider Fee Increase: Annual fee increases to \$11.3 billion through 2016. (HR 3590, Sec. 9010 and H.R. 4872, Sec. 1406)
<p>2016</p>	<p>New Taxes, Credits and Fees</p>	<ul style="list-style-type: none"> • Individual Mandate Penalty Increase: Penalty for lack of coverage increases to the greater of \$695 or 2.5% of taxable income. (HR 3590, sec. 1501/sec. 10106; and H.R. 4872, Sec. 1002)
	<p>Other Changes</p>	<ul style="list-style-type: none"> • State Compacts: Any states that have joined a compact that meets regulations issued in 2013 may begin operation of that compact (in other words, insurers who wish to sell to states within that compact may start to do so). (H.R. 3590, Sec. 1333)

2017	Insurance/Coverage Reforms	<ul style="list-style-type: none"> • <u>State-Based Health Insurance Exchange Expansion:</u> States are allowed to open up exchanges to employers with more than 100 employees. (H.R. 3590, Sec. 1312)
	Other Changes	<ul style="list-style-type: none"> • <u>State Waivers for New Health Insurance Requirements:</u> Beginning in 2017, states may obtain a 5-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. Waivers will not apply to ERISA provisions. (H.R. 3590, Sec. 1332)
2018	New Taxes, Credits and Fees	<ul style="list-style-type: none"> • <u>Excise Tax on High Cost Insurance Plans:</u> New excise tax applied to insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage (these thresholds will be indexed to the CPI-U for years beginning in 2020). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by \$1,650 for individual coverage and \$3,450 for family coverage. The threshold amounts may be adjusted upwards if healthcare costs increase more than expected prior to implementation of the excise tax and the amounts will be increased for firms that may have higher healthcare costs because of the age or gender of their workers. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under an FSA or HRA, employer contributions to an HSA, and coverage for supplementary health insurance coverage, excluding dental and vision coverage. (H.R. 3590, Sec. 9001) • <u>Pharmaceutical Manufacturing Fee Increase:</u> Annual fee increases to \$4.2 billion before dropping down to \$2.8 billion in 2019 and beyond. (H.R. 3590, Sec. 9008) • <u>Health Insurance Provider Fee Increase:</u> Annual fee increases to \$14.3 billion. For subsequent years, the fee is increased over the previous year by the rate of premium growth. (HR 3590, Sec. 9010 and H.R. 4872, Sec. 1406)